Meaningful Use Workgroup
Subgroup #2: Engaging Patients & Families
Draft Transcript
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Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you, good morning everyone, this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Meaningful Use Workgroup Subgroup #2, Engaging Patients and Families in their care. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please make sure you identify yourself before speaking. I'll now take roll. Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks. Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Charlene. Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Leslie. Neil Calman?

Neil Calman – The Institute for Family Health – President and Co-founder

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Neil. Paul Tang? And are there any staff on the line?

Michelle Nelson – Office of the National Coordinator

Michelle Nelson.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle. Okay I'll turn it back over to you Christine.

Christine Bechtel – National Partnership for Women & Families

Great, well, good morning everybody and thanks for joining us. We have 90 minutes today which is terrific because our agenda will sound deceptively short and simple, but I think it's not quite there. So, from the last call, we left off having completed the first three of four domains. And Neil, to catch you up a little bit we have kind of potential functionalities or objectives built into four domains of patient center care, which is whole person care, care coordination communication, patient support and empowerment, and ready access for care. So, we have gone through a first cut of the first three. We are now in the fourth, which is ready access to care, and we're going to talk about that today and hopefully get through that. I know Paul intended to send comments, Paul Tang, on the ready access bucket, but the attachments he sent didn't come through, so we're awaiting that. He may be able to join us a little later; it's a little early for him now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I am here, Christine.

Christine Bechtel – National Partnership for Women & Families

Oh, you are, hi, did you…?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I will go look for the attachments.

Christine Bechtel – National Partnership for Women & Families

Okay, great, great, great. Good, so that's great because at least Paul will be able to give his input today on the phone as well. So, that's great; we have the full work subgroup together. So, we're going to, I think, start off in the ready access bucket and kind of go through that and then we need to do two other things. One is, we need to go back through to some of the patient-reported data elements that we'd already identified and Leslie, I know you and maybe others were at the patient reported data hearing, Paul as well, right Paul, you were there?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes.

Christine Bechtel – National Partnership for Women & Families

Yeah, so, you know, if we could maybe get some feedback from you all on what the outcomes of that hearing were and ways that we might approach some of the patient reported, you know, kind of functionality that we have built into this framework already, then I think we can do some revising on that. And then the third piece is that we need to, you know, begin the work of getting this to be something that is a little more parsimonious.

And I think what I would like to propose in that is that we come up with kind of a set of principles or criteria that we could use to go back through offline and suggest some ways that different items could be combined or that things may be able to be eliminated based on what's in Stage 1 and Stage 2. So, I've got a couple thoughts on some criteria that we might use to achieve parsimony but I thought we could have a discussion about how to more fully develop that approach. And then we can do the work of being parsimonious offline before our next call. So, does that sound good to everybody? Anybody have additions or edits to that agenda? Okay, great, so let's dive in and we'll start with ready access.

As you all recall, one of the basis for going through and filling out the first version of this was some of the work that the Standards Committee had done through their Consumer Engagement Power Team, and then also, of course, looking at the set of principles that we started with, and so some of the things that kind of came there -- and this is, I think, a bucket that needs a lot of work and a lot of clear thinking. Some of the kind of functions or questions that were raised were around how do we facilitate or can we facilitate eVisits, you know, secure messaging, which is already in Stage 2 or well we don't know that, but it's proposed for Stage 2, should there be some kind of Skype capacity or eChat, other folks have raised kind of the administrative forms piece and we had a little bit of discussion about that last time. And we also need to think about the role of mobile devices.

So this is an area where it's a little less clear to me how we want to approach that. So I'll open it up to you all to think about what is it in Meaningful Use that we could do or should do rather to support better access to care electronically, and also by doing so create efficiencies for providers whether they're EP or EH and I think that's going to be a very…it could be two different sort of sets of things. So, I'll open it up to the group for conversation.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So this is Leslie, and one of the things we heard I think a lot is that people have different needs for information. They might all get the same information, but different views and different timeliness, and one idea that started to emerge throughout the day was to have an electronic health record allow for other systems to communicate with it, not just in our normal transaction, but actually have an API or be able to do a patient-facing system or a communication platform or collaborative platform that can actually bolt onto an EHR, because there was a lot of, I think, actually, Charlene brought it up and that's the EHR isn't the end-all, it's not designed to be where everything happens, but it's designed to be informed and informing.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, potentially looking to have policy that says that an EHR will communicate with other more collaborate care systems and in a standardized way and then we kind of shoot off from there or suggest a framework for a standards-based API so that we can get to the EHR as an informing and informed system. But the idea of a single bucket when you have community of care or when you have patients and their families engaging is probably not realistic. I mean, that was my big takeaway for the last week. I'd love to hear your comments too, Paul and Charlene.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

You know, this is Charlene, I saw a piece of the technology and I agree with what Leslie said is, you know, we've got to get out -- if we're going to make this transition to a patient-centered delivery system we really have to kind of get out of the venue specific, but I saw a piece of technology which again is communication technology that based on if I'm a patient who I call it tracks who my caregivers are, all of a sudden that care team just gets created by my interaction, you know, so there's emerging technology out there that supports – again, that's ready access. So, if I want to call Christine I would say call Christine, it would know who you are and where you are, and that kind of stuff. So, you know, there's a lot of emerging types of technology out there that support this collaborative care model.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You know, actually, this is Paul, one of the metaphors that was interesting, Nikolai actually had a number of good thoughts, but one of the things he had when he was in the hospital was essentially a patient whiteboard and in a sense that metaphor helped him figure out, gosh who is doing what to me on this day? Now in the inpatient setting, I mean your day is sort of your life and your coordination and probably, at least, what I'm imaging to be his patient whiteboard was the central clearinghouse for who is going to touch me today and what are they thinking and that gave him a view and also it gave him a way of, you know, oh gosh -- am I supposed to go to that procedure? -- that's essentially reconciliation, and if we could have that same kind of whiteboard for your care and your care plan, to me it seems like an interesting metaphor for how can a patient both be informed as well as know when to interject, you know, some kind of reconciling information.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And this is Charlene again. One of the requirements coming up again from the care coordination group is the ability, not only for the patient, but the caregiver to track that patient's progress kind of against their care plan and that same concept, if you will, so that view.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Your right, I mean, in other words, on the professional side of this house it would be really nice for us to help keep track of what everybody's doing.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Christine Bechtel – National Partnership for Women & Families

So, okay, so what I'm capturing from this is for in the hospital, some kind of what we'll call a patient whiteboard which would be a central clearinghouse for which care team members are going to interact with the patient or their family today and for what purpose, and it would include the ability to track progress against the care plan, and for the patient or their caregiver to input information or give feedback on the information that is there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, and I was saying that metaphor could be used across the board.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, it's broader than just …

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, I just thought it was really nice because you have so many things going on in one place that that is why the whiteboard was so helpful, but that's true in two ways, for the ambulatory is one, it's true across a more time continuum and space. And the other it is just as informative to the professionals as it is to the patient.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Christine Bechtel – National Partnership for Women & Families

So how is it different from an improved care plan in the EP setting?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The care plan is like, well, it's thought of as a document. So, one, it doesn't exist in the multidisciplinary world, certainly in the outpatient setting and two it's static versus a whiteboard by its implication is the reason it's a whiteboard and it's great is because things are changing all the time and you can update and edit and so that really struck me as a nice metaphor for this.

Christine Bechtel – National Partnership for Women & Families

Okay, I gotcha. So it's more of an interactive collaborative?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, I think that's back to the point that not everything is associated with a document, you know, not everything. There is communication that is comparative for all members, but it sits somewhat apart and above.

Christine Bechtel – National Partnership for Women & Families

Yes.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

But it's informing and informed. So, the whiteboard is a perfect metaphor, you're right Paul, the other thing that Nikolai brought up was -- and I don't know, it's probably not under easy access -- but it was that the patient intolerances also be noted in the same way a drug-drug interaction might be noted in CPOE and potentially right on the wristband of the patient so that we have the notion of intolerances for food or allergies, or procedures that the patient wants to make sure is reflected in their care.

Christine Bechtel – National Partnership for Women & Families

So, this I think is also another way, if you have a care plan that is, or it's another way that if you have this functionality first of all I think you could integrate the care plan notion into that and not have it as a separate dimension, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

To not have care plan in a separate dimension?

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, I think that's exactly right. I think we're bringing interactivity to the care plan.

Christine Bechtel – National Partnership for Women & Families

Yeah, exactly. Right, so, I think there are a couple of actually other things that could be incorporated under this, you know, when we get to the sort of ways that we want to be combining functions and functionality.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Christine Bechtel – National Partnership for Women & Families

Because I think if you get it into one place then it can be used, the functionality is there and clinicians can use it in the ways that makes sense in their practice or in their facility. So, I think that makes sense, when I think about ready access. So, I've got that captured. When I think about ready access I'm thinking not just thought about access to information, I think we have a lot of kind of access to information type things in other pieces of the framework. But how do you get access to care and the care team electronically in a more efficient way, you know, I think back to what Neil sort of talked about in a Policy Committee meeting probably two years ago, you know, how do we open up communication outside the five-minute phone call or the seven minute office visit? So, I think those are the other themes of, you know, is there an eVisit thing? Do we want to create a capability for, you know, that has more kind of a video kind of functionality, you know, things like that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, one of the comments I made and nobody got is I think it's worth, so the thing that we are going to be guaranteed is that technology will change quickly.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And I don't think we want our recommendations to be tethered to today or even what we think it's going to be tomorrow, but really be technology agnostic. So, the idea is what we talked about … I mean, I really think this is one a very cross-cutting but two, very fundamental function we just talked about this whole interactive care plan. So, the things that support that -- so we want the EHR and the patient portal PHR to support this -- both the access and the ability to update with attributions this whiteboard. I'm not sure that we want to prescribe whether its video or Skype, or any of these technologies, we just want that kind of participation and interaction.

Christine Bechtel – National Partnership for Women & Families

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And that links in, because, you know, the point, this bidirectional communication, this communication platform whatever we call it just pervades the care coordination space.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

It's really a collaborative care platform, and maybe the whiteboard is a great metaphor for that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I think this interactive care plan, this whiteboard is one kind of functionality, that is sort of … it doesn't say how things should be done but it has a lot of attributes and maybe we name those attributes at least to help explain it to others.

Christine Bechtel – National Partnership for Women & Families

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The other one we had under ready access was "eVisits," and I think that concept is important, how it's done and that is why I was saying, well I think we should avoid the technology itself, but the concept that you can have a professional consultation is what we're saying as well, and those are two different things. So, we have this electric whiteboard and we have this consultative feature, and actually the way I said it may be a good way so there are multiple parties that can be involved in a consultation. The implication is that an eVisit is between a provider and a patient, but there are other important efficient cost effective ways of using technology to conduct consultations. So, provider to provider is also a legitimate way, now that's not reinforced by today's payment system but that's one of the things we're trying to be agnostic about too.

Christine Bechtel – National Partnership for Women & Families

Yes, right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

There was a testimony given to us given to us by an organization that did doc to doc communications, I think you guys remember that, although it might have been care coordination and not engagement, but it gets to Paul's point, but also that these consultations can both be asynchronous or synchronous because there's a lot of benefit in sending a photo in a message and getting a consultation and not having to have that face-to-face eVisit. So, there's a lot of ways to still make a technology work.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, let me maybe clarify or correct your impression about eVisits, the vast majority of people who talk about eVisits are asynchronous.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, there is no … I mean, that's one of the reasons "telemedicine" of past failed is the synchronicity, so really when we talk about eVisits it's almost exclusively asynchronous.

Christine Bechtel – National Partnership for Women & Families

And Paul when you say telemedicine failed because it was synchronous and there wasn't … I mean, can you say more?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, so in the '80s there was this push towards "telemedicine," one was that it was largely expensive a lot because technology was expensive back then, but a key component was that you had to have either the patient and provider there at the same time at the same place, well virtually or they also … there were some state laws that required you to have the provider and the provider together with the patient, so it just became a nightmare to schedule and very expensive from either a cost or a time point of view when most of the time you could do it asynchronously.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And so a lot of the efficiency comes from that.

Christine Bechtel – National Partnership for Women & Families

Okay, gotcha. So, eVisits is something that we're thinking of as a separate piece from the whiteboard, although, you know, it could support the whiteboard in some way, but it's really about consultations between patients and care team members, it could be synchronous or asynchronous, but the provider to provider consult, would that go here or is that something that is more relevant for the care coordination subgroup?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You're right, you're right. The only way I brought it in was to, just like we sort of generalized the patient whiteboard to interactive care plans, I was trying to generalize the need for human to human asynchronous consultation electronically.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I mean, so we can roll it back up into MU, you know, but, yes you're right, the patient provider piece is in here. We just want to put a note so our other folks, our care coordination subgroup, knows about this or we can talk about it, you know, in the MU Workgroup.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And Leslie and I are on that, so we'll transcend, okay?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay and we'll just bring it back up to the MU Workgroup basically.

Christine Bechtel – National Partnership for Women & Families

Yeah, and we actually have a list at the end of this document of things that we want to…you know, we may want to feed into other groups when we're done. So, I've got that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

All right. Just to give you a little bit of vernacular. One of the ways this is described in conversation or literature is the patient's side is eVisit and the doc to doc side is eConsults, but what we're trying to do is combine that in the function, what we really need to do is use electronic communication.

Christine Bechtel – National Partnership for Women & Families

So, let's talk about what electronic communication means, is eVisit or eConsult enough to be clear to people or do we need to say what we're talking about here is secure messaging and, you know, X-Y-Z?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We could give examples and in the so-called preamble if we've got to explain that both of these cases are in today's payment system, uncompensated, which is why people are not taking advantage of it.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, Paul, this is Charlene, we've been working on kind of some use cases in the -- are these just two use cases again -- we want to make sure that we highlight? Even though I think I totally agree with where you're going relative to enabling the communication.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Use cases for which, Charlene?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Just as we're looking through, in terms of as we move to standards, we've got to support these use cases whether it's an eVisit or whether it's an eConsult.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, yes, so these are, yes, these are good.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

They're solid?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

To be explicit about and they have both technical, and policy, and payment implications.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So they really are very nice use cases.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So, we've been trying to like carve out those use cases.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

But these are really nice and concrete.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I mean, they fit into care coordination too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, right. See, the nice part is these both fit in care coordination as you mentioned, one maybe just we're tethered to this word, only fits in patient engagement.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Christine Bechtel – National Partnership for Women & Families

So, but I think what we're saying is we want to create the technical capacity to perform these functions.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Christine Bechtel – National Partnership for Women & Families

But, given that this, you know, ties very directly into the way we pay clinicians, you know, the idea that we would say, you know, 50% of your visits must be eVisits, it's not going to happen. So what we're trying to do is create the capacity and then hope the future payment models, you know, will support its use.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Christine Bechtel – National Partnership for Women & Families

So, in every other area we sort of have, you know, a verb, right, as we're describing the concept we're trying to achieve or, you know, so previously we've had, you know, make available an after visit summary or implement patient, for preference-sensitive care or receive alerts for drug recalls. So what's the verb here? Support the capacity for eVisits and then folks will know what we mean is secure messaging and I don't know what we mean beyond secure messaging, I don't know what the functional capabilities are.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, maybe like you said, the verb is support, support and the general term would be online consultation. The specific for in our category is eVisits, in other words the ability to have an online encounter.

Christine Bechtel – National Partnership for Women & Families

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well let's see, we are doing more than that, so.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

You are doing more than that, there's more.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct, yeah so there's an eVisit where there is a specific provider patient "encounter" that doesn't mean it's synchronous.

Christine Bechtel – National Partnership for Women & Families

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

There's some information and you're expecting some advice or feedback back and that constitutes the "encounter" which actually may occur over multiple messages. Then the piece -- and I don't know that we want to put; I don't know whether we're putting it in the same category -- was this whole upload of home information, whether it is ODLs or device information. We might categorize it separately because there's so much, you know, like in Charlene's use case, you can describe and deal with in this "eVisit" or this on-line encounter that separate uploads. I mean, that just calls into play several other issues and I don't know that we want to mash it altogether.

Christine Bechtel – National Partnership for Women & Families

Yeah, I think …

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

From a vendor perspective you would say we've got, you know, for certification you've got to support eVisits, especially if there was use case that was developed by one, we'd know what that means. Now, from the provider's side, you know, it might be different, but …

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well …

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We'd have to spec it out and work through standards and all that, but …

Neil Calman – The Institute for Family Health – President and Co-founder

This is Neil, the one thing I can say I think that's different between secure messaging and an eVisit is that, you know, in a secure message you're basically just communicating back and forth, but in an eVisit you're going to want to have the full capabilities of doing a lot of the functionality that you would do during a regular visit like writing orders, updating problem list, you know, generating summary documents things like that where, you know, I think you could begin to call out some of the functionality that eVisit has that's above and beyond, and wraps around just a bilateral communication. It's really about the visit not just about a conversation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, that's a good point.

Neil Calman – The Institute for Family Health – President and Co-founder

That also leads you to be able to do things that later are going to be important like generate information, you know, that might be able to drop a bill or, you know, do some of the business part of what it is capture procedures that are …

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Oh, yeah, you're right, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, maybe what we do is, as Neil suggested, let's keep the "online encounter" or the "eVisit" in one bucket and, actually, let's use -- maybe we should use the title of our hearing as the other bucket, i.e., patient generated data, because that would accommodate the -- I'm just telling you something -- and it would accommodate the remote monitoring devices in the ODLs, do you see what I'm saying?

Christine Bechtel – National Partnership for Women & Families

Yeah, we have those, so we have in sort of our different bucket, we actually have -- it's under the view, download, transmit report, we have received data from telemedicine on biomedical devices, we have information reconciliation, we have observations of daily living, patient-created health goals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I guess what I'm suggesting is we were oriented toward function, and maybe in Stage 3 we're breaking out to what do we need to get done? And what we've said so far are much more in the latter category, the care team whiteboard is not an EHR function, it is a clinical function that needs to be accomplished. On-line consultation is a clinical function and addressing patient generated data is a clinical function regardless of the view, download access. Do you see what I'm saying?

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

In the past we've been oriented towards EHR functions because we had to sort of kick start this stuff, but now just like we're moving towards outcome measures, we should be moving towards outcome functions.

Christine Bechtel – National Partnership for Women & Families

I like that idea in theory. I think I could fall off really fast though, because like an on-line consult you could argue is a functionality as well as a clinical, you know, function. I start to lose the distinction relatively quickly.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I did too a little.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Christine Bechtel – National Partnership for Women & Families

But, I really like the idea. Because one of the things that we definitely need to do to when we get to the sort of, you know, part where we need to pare this down is to use some criteria, one of them needs to be is this about improving outcomes, is this about, you know, care delivery and so the idea that we have a consistency between, all right Stage 3 is supposed to be about outcomes, so how about, you know, we might, could be the only group that ends up doing it, but how about instead of saying view, download, transmit and report you say, you know, that the ability to handle patient generated data and that's family health history, that's patient generated health goals, that's, you know, whatever and it's kind of the end result and then the functions need to be sort of maybe pointed out or built out in another way. So, I mean I like the idea and I can take a shot at trying to reorient if folks want. It's just I think there are a couple of areas I'm not sure how we'd handle.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Your right. So, I'll go back and look at our other matrix.

Christine Bechtel – National Partnership for Women & Families

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm thinking it might be a different column 1 -- anyway, let me sort of see if I can pull up one of our old matrixes and see if that's the way it works.

Christine Bechtel – National Partnership for Women & Families

Okay. So, but so in the meantime what I have under ready access is two things. One is access and update patient whiteboard for care and for care planning, right? Which is this collaborative care platform. In fact I'm just going to take out -- okay, so it will take access and update patient whiteboard, e.g., a collaborative care platform and then I've got some …

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Christine Bechtel – National Partnership for Women & Families

I'm sorry?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, that's fine.

Christine Bechtel – National Partnership for Women & Families

Okay, so that's a central clearinghouse for care team members to interact with patients, it includes the ability to track progress against the care plan and for the patient and caregiver to input information or give feedback on the information that is there, it's interactive, it's collaborative, it's dynamic, it's not simply a static document. The second component that we have here is create or support the capacity for on-line visits and consuls, e.g. online encounters which could include secure messaging, uploading patient information, things like that. I want to come back to Neil's point, because I think it's right, but I think … let me just make sure I get it.

When you do an eVisit or an online encounter regardless of sort of the functionality it uses, you're going to want access to and the ability to update the problem list and generate orders. Those functions are already built-in to the EHR. Do they need to be called out separately in some respects for an on-line encounter or would they still be able to be used in exactly the same way, it's just that what you really need to probably is incorporate the back-and-forth of the encounter itself into the record.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right, so this is Leslie, the technology or the standards that are being developed allow for the things to go along with that message. The idea whether that's an observation, whether that's a result, whether that has some actionable activities associated with it, whether it's tied to an encounter, whether it's tied to something else. So, if we could expand on that to make sure that all of the necessary metadata is available so that if that comes in as a result with an expectation of a confirmation or an expectation of a consult back that structure exists. So, I think we want to make sure that the messaging goes forward and that it's ingestible and interoperable, and actionable once it gets to one or many parties. So, I think we can just add that in expectations.

Christine Bechtel – National Partnership for Women & Families

Okay, I think I've got that. So, that's this notion that you need to make sure, and it's a two-way street, right? That other data is needed … the other data needed to support the encounter is available from the EHR, but also that information generated from the encounter is digestible and you can incorporate it into the EHR. Is that what you're saying, Leslie?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I am, but also understand the notion that there's multiple, you know, that there are -- it's not just a bilateral communication and so you have to inform, you know, Dr. A is the sender, Dr. B is the receiver, patient C has or patient has input, it's all that sort of information is available and they're working towards that on transitions of care and I just don't think we -- I think we need to made sure that to Neil's point if we design or we set in policy the idea that any communication can be actionable for administrative, for billing, as well as clinical information we're covered.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I think that point, that communication, I think that's an important point to keep kind of at the forefront, because where I get a little bit lost is some of this communication happens out in space, but if we really want to link it to payment we need to just make sure that we don't lose that stream.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, that's the importance of this concept encounter.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And that was the point Neil's making, is we need to preserve the concept of encounter so that it can have some of these other downstream effects.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Christine Bechtel – National Partnership for Women & Families

Okay. Okay, all right I think I've got it, you guys can revise it. Is there anything else that should go into this area of online access, I mean, not online access, ready access. I mean our focus groups and our work with patients and families, you know, they talk a lot about the conveniences, you know, I need to be able to make appointments online or do admin forms online, that the appointments wait times, those are real access issues for people. As actually is linguistic competence and things like that as well, but I think we've got that in other places. Is there anything from the administrative side that should be considered here?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

The only other, this is coming from -- this is Charlene -- coming from care coordination, it's access to, and again this can be in the context of the care plan and I'm fine if we put it there, but it's access to -- and we're hearing this a lot -- okay, when I go in, I want to refer my patients to some nonclinical services, right?

Christine Bechtel – National Partnership for Women & Families

Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Community services or -- so I don't know where ready access to that kind of -- those services in the context of you know, my life, basically.

Christine Bechtel – National Partnership for Women & Families

Yeah, that's actually a huge issue for patients and families. So it would be great if the electronic record could make that easier and I'm not sure how to do that other than, you know, I mean it could be a form of patient generated data that the patient says, you know, I'm interested in these services and supports in my community. It could be that there is an ordering function written, that is essentially okay, you know, it's kind of an information prescription or I'm prescribing for you the, you know, the following community-based resources that can help support your health and wellness in these ways. What do folks think from the practicing clinician viewpoint?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

This is Charlene -- like if you look at the mental health or substance abuse and you're with a caregiver and they'll say or the law says you've got to go to AAA or whatever, AA, you know, just showing them, okay, here is when the meeting is on, this is when you need to, you know, that kind of stuff, you know, is like …

Christine Bechtel – National Partnership for Women & Families

Right, or it could be Meals on Wheels; it could be, you know, a diabetic education class or support group on weight loss, whatever.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, so that's the other kind of …

Neil Calman – The Institute for Family Health – President and Cofounder

But, how is that any different than, just, you know responding to a secure message and just, you know, sending somebody a piece of advice? I guess I'm getting a little lost here.

Christine Bechtel – National Partnership for Women & Families

Well, part of what we're trying to figure out is, is there a way to do a better job than just to say you should be in a weight loss support group. Is there a way that the electronic record could make it easier for patients or for providers to really connect them to community specific resources and you know, there's a challenge there in that every community is different, right.

Neil Calman – The Institute for Family Health – President and Co-founder

So, I can give you example of something that we're doing, but I don't know how one would generalize it. So, we have a smoking quit hotline that's run by the New York State Department of Health.

Christine Bechtel – National Partnership for Women & Families

Right.

Neil Calman – The Institute for Family Health – President and Co-founder

So, we put the facsimile of, it called fax to quit, but we don't do it through fax, but we put that form in our system and its auto populated by everything that's in our electronic health record. So, instead of somebody filling out a whole form, they can refer somebody to a fax to quit line with literally like a single keystroke and that triggers a whole process from the State Department of Health. So, I think these things are very individual you kind of have to know like how those agencies, you know, accept referrals.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Neil Calman – The Institute for Family Health – President and Co-founder

You know, what you would do to try to facilitate that stuff. I just can't imagine sort of structuring that into Meaningful Use, because there's no real standards for how agencies accept referrals.

Christine Bechtel – National Partnership for Women & Families

Right, right, right, right.

Neil Calman – The Institute for Family Health – President and Co-founder

You know across multiple agencies.

Christine Bechtel – National Partnership for Women & Families

But, Neil, I guess here's the question for me, would it be -- would it make it more efficient and effective and maybe get into, therefore get it used more, if the EHR had the, or something that bolts on, I don't know, has the capacity to be customized in a way that you could individually list the community resources that you refer to most often and maybe even on the patient side, the ability for the patient to sort of flag what resources they would be interested in so that the connecting becomes a little bit more automated and a little bit more efficient so at least the patient knows, oh I could, you know, there is a resource. It does not go so far as to, you know, enroll them in the program or anything like that where there really is a need for like human interaction, but does it help you to have a customizable kind of feature that would allow you to customize, here's the list of resources available in our community for different purposes.

Neil Calman – The Institute for Family Health – President and Co-founder

Yeah, I guess my fear would be mixing this up with medical stuff, because, you know, we're creating a whole process of transferring CCD documents as kind of a way of transferring medical information, here's a place where, you know, people would probably want extremely limited information tests from their electronic health record.

Christine Bechtel – National Partnership for Women & Families

Oh, or not, right.

Neil Calman – The Institute for Family Health – President and Co-founder

Or none, right, we're not -- and I'm not sure like how you would go about doing anything but sort of populating it by hand. I mean, some people wouldn't even want their Social Security number passed or their, you know, health ID or anything, you know, it's just …

Christine Bechtel – National Partnership for Women & Families

It's something to think about. I'm not …

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie. I think that the idea of lists are probably obsolete -- I mean, when was the last time you opened a phone directory? So, what we want to make sure we do is say that the community resources are available electronically that can be referred by the physician or potentially we have the notion that community partners also have access or can sign up to be involved in secure messaging or in a collaborative platform. So, did you actually have an efficient way to communicate, we don't really know how those communities except things. Today they do it as a fax, right or they do it with a phone call. But building lists that are going to be changed every day, I think becomes difficult.

Christine Bechtel – National Partnership for Women & Families

Okay, before we …

Neil Calman – The Institute for Family Health – President and Co-founder

I also think the conversations that…I mean we do a lot of this stuff, the conversations that you have with these agencies are so complex. I mean the conversations you have with somebody that you are referring for housing, you know, is a real conversation, you know, there's 20 pieces that go back and forth during the conversation and you could automate that stuff or figure out what those pieces are, you know, I just…I'm not sure we're going to get much mileage out of this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm with Neil, I mean this is what we work on in my day job, but this is premature for Stage 3. We can put this in our placeholder for future stages, you know, which it will be, but right now it would be an imposition with an uncertain…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Value.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Outcome, uncertain value, there is no receiver, there is no maintained data, there's all kind of things and that's -- I don't know; it wouldn't be appropriate to specify for an EHR at this point in time.

Christine Bechtel – National Partnership for Women & Families

And, I'm hearing that from the group. I think, you know, in response to Charlene's question, I think the issue is that we've got to be very clear about the problem we're trying to solve in this case and I think the problem we're trying to solve is that there aren't enough referrals that happen and that the process is fairly cumbersome, so that's what I was trying to get at. I don't know if it's something…we can certainly put it as a placeholder for future stages. I don't know if it's something though that would be worth trying to get some feedback from the public in our feed process in terms of is there a way to make community connecting…patients and families with community resources easier using, you know, Meaningful Use as a vehicle, everybody might say no, you know, not appropriate that's fine. But I don't know if there are other things happening and if there's a way to solve some of the challenges here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think there will be the future. The current approach that I think both Neil and we take is these are things that we put in our "after visit summary" so you can pull in information that may be useful to this particular patient and you're doing it by patient, but the automated connectivity and the amount of information and what information that has to be exchanged is highly variable and very location specific.

Christine Bechtel – National Partnership for Women & Families

Yes, okay. So, are we, I think, so that doesn't get to my question around is there a role here for administrative, you know, functions, on-line appointment scheduling, things like that or pre-visit, you know, we have some stuff I believe earlier around pre-visit prep tools, we do, but are there any other kind of admin related access pieces like appointment scheduling that people feel like should go into Meaningful Use or are they more market force driven.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think they're more market force driven.

Neil Calman – The Institute for Family Health – President and Co-founder

Well, there's one that I would suggest and I don't know whether this is covered elsewhere because I haven't been able to be on a lot of the calls, but I think one of them is the ability to create almost a mandate for the ability for people to sign on to the portal to register for the use of the patient portal on-line without having to be present at the center and I think there are secure ways of doing that. In other words, to create access for people -- and my understanding in the way a lot of the portals work is people have to sort of get the sign-ons and do all the stuff when they're physically present at the center.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Neil Calman – The Institute for Family Health – President and Co-founder

Which I think creates a barrier for a lot of people and I think if we could call out sort of the need to create a secure process for people to be able to sign-on to their electronic portal for the first time without actually having to trigger, without actually having to be physically present at the center, I think that would make for a very important access issue, because when you do that, it enables somebody, even for a first visit, even if it's just a temporary sign-on, to literally be able to sort of register themselves, to provide a lot of pre-visit, pre-first visit information for providers that can be done in a very thoughtful way and, you know, not in a time rushed way and I think would make for the preliminary information that people have to work with and the whole record to be much more complete.

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, we've spent a lot, many years of time on this, but I think this is, the primary thing is authentication, and as you know we don't have authentication in this country as far as a national standard. So, I almost think of that as a privacy and security kind of topic along with standards.

Neil Calman – The Institute for Family Health – President and Co-founder

Well, the reason I brought it up, Paul, is because if you're just…let's say you've never been a patient at our health center before and you decide you're going to call up for an appointment and there's nothing you're going to have access to that you're not going to put in prior to that visit. I mean you don't have access to anything, there's nothing to authenticate, you're basically going on and registering for something. The authentication takes place when you arrive at the center the first time, you can authenticate the information that you had previously entered and basically say yes, that's all of the stuff that I put into the system and now you've authenticated your identity. But prior to the first visit, you don't have to do -- there's nothing to access for you to have to guarantee authentication for, that's what I was referring to, really.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so I see, that's an interesting thought. Now, the trouble is you still are not -- so, you are an individual, you create an account and there is really no -- you've created an account. So, no one can protect the thing that you just created against somebody else becoming you and even accessing what you put in so far. But the problem is, you have created an account on organization X's computer and all of a sudden they are responsible for the integrity and the security of that information. Do you see what I'm saying? I see the value proposition and how for that legitimate individual becoming authenticated after the fact, but before the fact, how do you make sure that you're being responsible enough not allowing anybody else to see this individual's records.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, this is Leslie, and one of the things we're talking about in privacy and security is sort of this notion of authentication or validation framework. Many states for instance I can log on and get all of my information about my taxes and interact on-line with that state and there's several different authentication tools to validate who I am before I create an account. And then create that account that I can renew my driver's license or I can get my tax information.

So, I think that Neil's right from a policy point of view we want to make sure, hey we're going to set the stage that there is a nationally recognized way to authenticate a patient and identify that patient and it doesn't mean a card it means a framework that we can create as secure and private, because that will promote adoption. Right now there's so many barriers to just say, hey I am who I am and I want to get on-line to get my record.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But, wait, do we have the framework -- I don't know that we have and privacy and security has looked at -I don't know that we have that yet so I don't know how that we can "force it."

Christine Bechtel – National Partnership for Women & Families

I think what I'd like to suggest is I've got some notes on it. I think this is one of the areas that we could refer to privacy and security folks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Christine Bechtel – National Partnership for Women & Families

To ask them to work with and Neil I'll make sure that they know to talk with you and with Leslie as well about what you're thoughts are, but I think it's probably more appropriate for them to tackle that. It is absolutely an access issue and so I'd like to see it and it may ultimately end up in this bucket, but let's start it with the privacy folks. Does that make sense?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Totally.

Christine Bechtel – National Partnership for Women & Families

Okay. All right, so the last thing we have on here is really this sort of role of mobile devices and that's a big area that I am not well-versed in, but we know that's a big access issue and particularly for underserved communities. Do we need to, I don't, you know, create something in Meaningful Use that essentially enables the capability for mobile device access to either secure messaging or to what's in your, you know, patient portal, your whiteboard, there's a lot of this that could be done via mobile access. What I don't know is, is it -- and I think it is a policy priority because it would really open up access -- but I don't know how to accomplish that in this regard.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Perhaps it's simply a statement that patient engaging systems or patient facing systems will have the ability to support mobile devices, a certain percentage.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think this sounds a lot like prescribing technology and …

Christine Bechtel – National Partnership for Women & Families

I know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And the market is already clearly driving this. And the other thing is we don't have all the kinks worked out of it, security and privacy, authentication. As you know most people don't want to have a…or many people don't want to have the pin on their phone, so there's lots of things that we could get wrapped up into when it's really one, there are some things that haven't been worked out and two, this really is a market thing. We don't have to say, oh, everybody should be using a Mac because think Mac … you know, it just doesn't make sense to prescribe how people do it.

Christine Bechtel – National Partnership for Women & Families

Yeah, I mean I agree with that on the other hand it's such an access issue that, you know, I just wonder if there is a kind of kinder gentler way, you know, that is maybe less prescriptive of technology but it's hard for me to imagine that generally speaking smart phones are going anywhere, obviously the technology is changing every day, but I'm not sure that the market is really going to drive mobile access in these cases, because, you know, healthcare is the last place on earth that there may be things convenient except for doctors, you know, like using iPhone Apps, you know, as they're delivering care, but we're not doing that for patients. You've seen the struggle just to give basic on-line access forget the phone thing. So, I'm worried that it's actually not drive by the market and I think actually has some implications for health disparities and health equities.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, I mean, I'd be interested in what Neil says as well. In our market…so once you have access like typically with a portal your driven to make; I mean, your customers are asking you to make it mobile today. I don't know what it is tomorrow, but that's what I mean by the market is driving this. Once you, you may be talking about people who already don't have access period. But once you do have access, once you have it electronically and once you make it available in a portal then the market drives you to where people, you know, want to access that stuff.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie, I think that's somewhat true, but right now we're seeing a lot of swirling going on in FDA about the use of mobile devices and privacy, and security, and encryption. We're seeing a lot of people trying to figure out just what is it you send on a mobile device, what is important and I agree with Christine that there isn't just a market issue because of the fear around privacy, security and all of that. So, by having it in policy there is an expectation for mobile use for patients and families helps us with access and then also helps to give the market some intelligence and government some push to make sure that we accommodate the mobile user.

Christine Bechtel – National Partnership for Women & Families

I think that's really well said Leslie. What would people think about asking our privacy and security folks to weigh in first and having a placeholder for a signal around easy access/mobile access?

Neil Calman – The Institute for Family Health – President and Co-founder

I think that's great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think ask them first, because the reason there are swirls is because we don't have the problem solved.

Christine Bechtel – National Partnership for Women & Families

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And it doesn't do good to force a non-solved problem down people's throat.

Christine Bechtel – National Partnership for Women & Families

Right, okay, all right. So, I'm going to put a placeholder in the matrix just that we are referring it so that we don't, you know, kind of lose sight of bringing it back in if it's appropriate. All right great. So anything else on … any other kind of objective or function that, or goal we're trying to achieve in ready access before we move to the next part of our agenda?

Neil Calman – The Institute for Family Health – President and Co-founder

Yeah, I just have another question, it's Neil.

Christine Bechtel – National Partnership for Women & Families

Yes?

Neil Calman – The Institute for Family Health – President and Co-founder

Just another note to self, was about the access to patient specific health information that we had called out previously.

Christine Bechtel – National Partnership for Women & Families

Yes.

Neil Calman – The Institute for Family Health – President and Co-founder

And thinking about how that's designed to be done through the portal, and not just at the time of a visit. So, that was something that at one point we chose to revisit in the future. But, you know, I'm thinking specifically because of this public access that's now available through Medline plus, you know, with Direct that basically there's no reason that systems shouldn't allow for people to access their own information, can have it directly linked to a database of explanatory sort of information on diseases, lab reports, drugs and other things. And I think using a free access government available resource for that makes it something that we can call out that really wouldn't add any expense at all to the system but provides an incredible amount of functionality for patients.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And this is Leslie, and obviously Healthwise is interested in that as well and we, as a nonprofit, also agree that the linkages need to support all providers of information content like the free providers in the NLM or others and so using the InfoButton standard has allowed for the continued use of free information. And I think that's an important concept because every time a patient has access to information they should have access to the explanation of what it means.

Christine Bechtel – National Partnership for Women & Families

So Neil, what we have in there…what we have in the matrix right now is patient specific education materials and reminders delivered in the top 10 primary languages for the top 100 diagnoses treatments and tests. So what you're saying is this is a little bit of an adaptation to Stage 1 and potentially Stage 2 in that, but in stages 1 and 2 the educational materials were already supposed to be electronically identified. But are you suggesting just a different sort of mechanism of delivery which is through potentially like, you know, on-line access or e-mail, or something like that, or what are you suggesting that's different?

Neil Calman – The Institute for Family Health – President and Co-founder

Yeah, I'm suggesting specifically through the mechanisms that we're calling out for patients to commute with providers that in the course of those communications or in accessing their records through a patient portal that, you know, I would say the terminology that's used which are standard, you know, lab tests, pharmaceuticals, problems in the problem list, things like that, our ability to be able to be linked through using standard nomenclature to either commercially available or publically available databases.

Christine Bechtel – National Partnership for Women & Families

Okay.

Neil Calman – The Institute for Family Health – President and Co-founder

You know, I think…

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And then, this is Leslie, and this is a great conversation because the idea of being able to have patient context path and linked means that the metadata is associated with the secure message, it's associated with that lab result, it's associated with that narrative coming from a physician or that order so that the patient can click at any time and see the education material for that particular context and it should be ubiquitous, the metadata should go in any type of transaction with that patient whether it's a portal, any other patient facing system, lab results, direct messaging or any other types of messaging.

Neil Calman – The Institute for Family Health – President and Co-founder

Thank you for translating, that's helpful.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

But, Leslie, what is this metadata? I mean, there's a lot of sources, I mean…

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, we're doing it right now in Stage 1 and Stage 2 when you say the words patient specific, the context is passed and so you have the problem list, chief complaint, principle diagnosis, lab results, patient age, gender, language and so forth. So, the context around the patient and the context around the provider has already been identified, now we need to make that the next step which says that context can be evoked at any time whether I'm in a message or whether I'm in an order, or whether I'm in a transcription, or lab result I can see what that means.

Christine Bechtel – National Partnership for Women & Families

Yeah, so I'm hearing two things and this is what I've captured and this document will again go out to you guys later today. So, I'm hearing two things. One is linkage to on-line resources that are going to help people interpret the information that they find in their record or in their secure message, or in their whatever. The second is then patient specific education resources that could also be delivered through the same channels, you know, that could be more generally kind of about your newly diagnosed condition or whatever, but that you need both. Did I get that right?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes.

Christine Bechtel – National Partnership for Women & Families

Okay, all right, all right, so I've got that, Neil, thank you.

Neil Calman – The Institute for Family Health – President and Co-founder

I'm going to have to sign off. I've got people piling up. So, I'll talk to you later.

Christine Bechtel – National Partnership for Women & Families

All right, we'll send this out later. Thank you.

Neil Calman – The Institute for Family Health – President and Co-founder

Bye-bye.

Christine Bechtel – National Partnership for Women & Families

Bye. So, all right, great, so again I'll send this out to folks later today and you can have your way with edits and suggestions. There are two other things that we need to accomplish or at least start in the next 25 minutes, so are folks okay to move on from this for now? Great, I'm going to take that as a yes.

The two things that we need to do next or at least get started with are one, kind of…we need to have a general discussion about how we're going to approach going back through this document and combining things and figuring out where, you know, there are a number of places where I think we're calling out things that looked separate, but in fact are linked and you really only need one and not both or whatever the case may be. And so we need some sort of thinking for what's appropriate for, you know, any kind of a Meaningful Use objective or functionality and what is it that's important for these in particular.

And then the second thing is to go back and revisit some of the patient generated data components and I actually think that these two issues of the kind of paring down and the patient generated data piece are very, very linked because I think there are ways that some of the patient generated data stuff could end up obviating the need for some of the other components that we have talked about be they here or in other places.

So, I think what we want to do is at least a first pass between now and our next call off line individually probably or, you know, we can talk about the process. I can take the first cut or whatever…where we can really kind of pare this sucker down and see if we can get it to be, you know, parsimonious, as we always say. So, I am inclined to actually start with talking about the approach to parsimony and laying out maybe some kind of principles or thoughts that we could use and then to come back to the patient reported data piece if we have time and if not ask, you know, Paul and Leslie, and my colleague Eva Powell who was there, you know, folks who were at the hearing to kind of do some off-line editing at the same time. Does that make sense to you guys?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Sounds good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Sure.

Christine Bechtel – National Partnership for Women & Families

Okay. All right, so if I thought about, you know, how we can approach kind of paring this down and creating some efficiency in our work here, I think there are a couple of things that we can do. One, is you know, look for the low hanging fruit where there is duplicity where we need to…duplicativeness, not duplicity that's different or we need to just combine, right? But there are a couple of other things that I wanted to raise and get you guy's feedback on.

One is it's possible that we can remove some of the things. There are a couple of things in here, not many, that are already either in Stage 1 or proposed in Stage 2, but that are just sort of tweaks and I think there are other things that are, you know, we should question, well if they were in Stage 1 and if they were in Stage 2, and they were in use and in use effectively, do they need to be in Stage 3 or will providers, as requirements, or will providers continue to use them because they were the first two stages. So, that might be one piece. Do you guys want to react to them individually? Do you want me to go through a couple and stop?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think that's appropriate. Another way I sort of wrote it down was not topped out. So, in other words, if already some of the things are 50 or even 80% it doesn't really change anybody's behavior to make it 90%, because one of the reasons we don't have it at 100% is because there are legitimate reasons why not, it could be the setting, whatever. So, the people who already have that much use are not going to stop if it is useful to them and we don't want to force something that is not useful or not feasible in their locale. So, I think that's an example where you don't keep piling on.

Christine Bechtel – National Partnership for Women & Families

Yeah, exactly. All right, the no pile on principle.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, it's not topped out. The other way to look at is it's not topped out because it's a little bit …

Christine Bechtel – National Partnership for Women & Families

Yes, right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The same principle.

Christine Bechtel – National Partnership for Women & Families

Yes, right exactly. Okay, so the second that I thought of is are the things, the functions and the kind of critical elements that are really needed to enable and support new models care that are being tested and implemented, they have many, many common elements around care coordination and patient engagement. So, if it's something like I would say for example maybe the eVisit, eConsult that's something where at least the functionality is needed, we may not have a big use requirement or any use requirement but we need to create the functionality to support those delivery system changes, that's a good thing. So, that would be the second kind of component I would suggest. Thoughts on that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I agree with that one too. Another way to think of it is, you know, we think of some of these things as best term but just because it tends to tether people, anchor people, but what you're describing is sort of an enabling platform or maybe it is an enabling floor, you put in functionality like our HIE thinking that you need to have…this is an example where we level the playing field so that everybody can build upon it but nobody wants to make the first move.

Christine Bechtel – National Partnership for Women & Families

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

What's the name of that concept? That's a good one Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, well it's enabling technology or in some sense it's a floor.

Christine Bechtel – National Partnership for Women & Families

Well, I liked Leslie's term which is give the market some intelligence, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't know that people would understand that.

Christine Bechtel – National Partnership for Women & Families

I know, I know. But, I get the point and we can write that out.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

It's a building block, you know, when you think of building something.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

It's a building block, kind of like your floor thing.

Christine Bechtel – National Partnership for Women & Families

Yes. Okay, so the third would be -- it should be somehow connected to the EHR, right? So, it either feeds to it or it pulls from it and if it doesn't meet that I think that's something that we have to sit back and ask about, so that's why I think we don't have a lot of the administrative maybe components in here, which actually is the next piece, which is that it's something that if it is something that we genuinely believe that the market forces are going to drive then it may not need to be in here and I think in some way that is connected to the first kind of, you know, not topped out principle that we have. But if we think the market is going to continue to drive it, the capacity has been created or it's just frankly something that the market will drive regardless of what's in Meaningful Use then I think we should question if it's a requirement or not. Does that make sense?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I like that one.

Christine Bechtel – National Partnership for Women & Families

Yeah, I figured. Okay, so the next would be, it's tied in some way to improving health outcomes or improving efficiency.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, one way to…what I wrote down was outcome oriented, which is what you just said, evidence-based to the extent possible. So, a lot of this stuff we don't have the evidence, let's say even health information exchange in some sense, but, you know, just have so much faith validity and it's sort of its tied with this enabling building block, but it's really giving functionality and outcomes oriented tests like we are doing with our quality measures.

Christine Bechtel – National Partnership for Women & Families

Yeah, I kind of like the face validity framing better in a way because for patient engagement we get stuck a whole lot on the evidence thing and it becomes a way that the status quo can creep back in. So, I would suggest it's got to have faith validity in terms of these other criteria, I mean that's sort of what this exercise is about. And I think you mean face validity that there's some linkage to outcomes. Is that what you mean?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, the concept is outcomes oriented and there's a couple tests of whether it's worth the cost of "implementing it" developing and implementing it. One is if you have evidence that is a good basis for saying; yeah I think that weighs in terms of the benefits over the cost at least, so the least test is that it has face validity. But, I think we ought to keep challenging ourselves to make sure that one, ask for more research should be done to know whether this is worth the cost and start building that evidence. I mean, I just think we need to start having, not start, but we need to have some validity in our request for functions to be developed as well.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie, and when we engage at totally new populations like patients involved in these activities the face validity and the outcomes may have nothing to do with the clinical outcomes and everything to do with what the patient goals are and what the patient wants from it. And, so the value principle is the patient who says I want to improve my quality of life, I want to make sure I manage my diabetes well or I just want to walk further. And so I don't think we can impose a value proposition on a population that has never been engaged in this way before. So, is the cost worth it of the system to engage the patient and we don't know, you know, we don't know.

The market might drive it because, like Bon Secours tells us they've added 250,000 patients each year that they didn't expect through engaging them on-line. Now the value proposition to them is it's increased their market share, that's a very valid business reason or Kaiser who says that their valid business reason for engaging the patient and family is that they've learned that in fact they've reduced that second heart attack by 90% and that value was there. So, they didn't anticipate in those two examples, they didn't anticipate, they were hopeful, but they didn't require any sort of proof up front and then if we ask the patient what's in it for them, if you have a small hospital here in Idaho who has patient signing up for their access to their records every 8 seconds, their value is just knowing it's there.

So, just like, if I have a savings account I might not go to it every day, but it's valuable to me to know that I can on-line. So, I get hung up with proposing value propositions for totally new populations and new functionality.

Christine Bechtel – National Partnership for Women & Families

And I have to say, I share Leslie's concern on that and partly it's because it's very difficult to put…there are very specific costs generally knowable costs associated with, you know, the various elements that are proposed in Meaningful Use and yet the benefits, you cannot quantify in the same fashion so it becomes an apples to oranges thing. So, I'm wondering if folks think that we have this sort of principle around outcomes oriented or to improve, you know, efficiency for patients or providers and that we've now of course just had this conversation as well that the kind of…some of the parts of all of these will be enough to knock out those things that, you know, don't have face validity or value rather than trying to articulate that in a way that I think…you know, I have concern, I hear Leslie has some concern, we all want everything to be valuable, we don't want this to fail. But, I think when people start to put dollars against…yeah but that's what patients want, you know, like how do you measure that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, wait a minute, nobody's talked about dollars.

Christine Bechtel – National Partnership for Women & Families

No, no I'm saying…I know, but what I'm saying is what I fear that that principle would be used to do is to say, well the cost of implementing a patient portal that has shared decision-making tools is going to be "x" because it's something you can quantify cost around. But, it's much harder to quantify the value of that to patients and I think it's too easy for people to take the kind of cost benefit piece and actually assign a dollar to a technology implementation, which is doable, that's all I'm saying. I'm not saying that's what you're doing; I think it becomes easy for others to do that though.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And, I mean Christine's right, this is a challenging one, because when you look at, you know, some of the hospitals and the practices who don't like have two nickels to run together it's a stretch and that's the feedback we hear, you know, I've got…how am I going to get these patients in the door, my populations don't want it, you know, so it…I don't know how you value it, but it's certainly a barrier at this point in time in the conversation.

Christine Bechtel – National Partnership for Women & Families

What if Paul we the kind of refrain to either that the information or the function is actionable for clinicians and patients both.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Actually, you know, you tested it…now that's interesting. I mean, so one, yes, but let me tell you what I got out of that statement, which is really important because what you said was when you say it's actionable that means that there is some value perceived by the healthcare team that says, oh, that's information that's part of decision-making and I can do something about it. And what that implies is that if fits into the clinical workflow and they can incorporate it in their decision-making, that's really, really important.

If you remember what…the…health design that is one of the two criteria. So, one was we were capturing ODLs but the other criteria, you know, that they were supposed to evaluated against is and that it can be incorporated in the clinical workflow, because it just doesn't matter if there is data being generated and it's not used.

Christine Bechtel – National Partnership for Women & Families

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And it's not that your forcing them to use to use it, if it's valuable than they we use it. If it's valuable and you make it accessible to them cognitively.

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's a really nice test.

Christine Bechtel – National Partnership for Women & Families

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's just my way of endorsing what you said.

Christine Bechtel – National Partnership for Women & Families

Well thank you and I think that's my way of getting to the value piece.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

That's really good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, that's it, it's the same thing.

Christine Bechtel – National Partnership for Women & Families

Yes. So, okay, so the last one that I thought a lot about was that it's something that supports or even accelerates culture change for clinicians or patients and I think the whiteboard is a good example of that. This in my mind when I stepped back and kind of looked at the thoughts that we've just laid out, one of the things that was missing was this notion that, you know, you could have something that would be fundamentally sort of different and we're creating the capacity, you know, but it's a fundamentally different way to really support interaction between patients and care team members but that it's, you know, not something that market forces are probably doing to drive, you know, it's definitely outcomes oriented, it's definitely supported by information from the EHR and feeds information back to the EHR.

So, I think that kind of idea of culture change though was an important one for me to pick up any sort of gaps things just as question now how I suggest that we use…just before I open it up to discuss that one…how we use these is that, you know, I don't think every single criteria or function, or concept that we're laying out have to meet all seven, but if it meets only one, you know, that's probably an issue and we need to, you know, take a harder look at that, but that we would go and kind of evaluate these things and see how they stack up and identify ones that don't meet very many of these principles. So, what do you guys think about the last one I've proposed around culture change for clinicians or patients?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I wonder if there's a different way to state it, so that we don't have a goal of changing culture.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It may go back to the outcomes oriented. So, I think we recognize the benefit of the deficit in care coordination we have today and the benefit of doing that better and who has to be coordinated. We come up with a concept, an interactive care plan or the patient whiteboard and yes that causes, that would require a culture change, but that's not the goal is to change culture.

Christine Bechtel – National Partnership for Women & Families

Yeah, and I see where you're going and I think it's probably right. What I was trying to get at was if it's something that is new and innovative it probably should be looked at as something that is important that, you know, I was going to say more, but at least as important as some of the things that we know are sort of already traditionally done. But this is really new and innovative and supports -- maybe it comes back to enabling delivery system reform. But it really supports, you know, everybody knows that healthcare has to change, whether it's culture, cost, quality, value or whatever. And so how do we use technology in a way that is innovative and supportive of positive change, not necessarily culture change, but that's part of it. How do we use that in this way? I think there's a lot of value in that as opposed to just automating the current system, that was what I was trying to capture here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well we neither have an objective of automating the current nor I think do we have an objective of going out just to change culture. What about this, aligning with the national quality strategy. So care coordination and prevention and patient engagement and families are part of that. If it requires a culture change that's fine and we're hoping to facilitate that, but I don't know that it's an objective.

Christine Bechtel – National Partnership for Women & Families

Right, but I think aligns with the national quality strategy is still pretty broad. I mean, right, what we're trying to do is support change, positive change whether it's like I said culture change or cost change or outcomes changes, so that's what I was trying to get at. Maybe it doesn't, maybe we don't need to have it, why don't we start without it, use the 6 that we've got and see what falls out and, you know, maybe we're all set and this is what we need. Does that make sense or sound good to people?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, I have a couple of others to suggest, to consider.

Christine Bechtel – National Partnership for Women & Families

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

One is widely applicable, because I think there's a danger in finding something in one of the subspecialties that says, well that would be useful, yes it would be but this is an EHR program not only for all specialties, just the entire country and it just doesn't make sense to drill down on specific things, because it's just not a floor.

Christine Bechtel – National Partnership for Women & Families

Yes or if it is it's something that we would check through a menu.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Christine Bechtel – National Partnership for Women & Families

Yes, I think that's smart.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, actually I'm a little hesitant about that because menu has turned out to be one of our ways to signal the market and it turned out to be a very potent way. So, we'd like to reserve menu almost like a phase thing rather than oh, it just applies to this little specialty over here and this menu item applies to that specialty over there, that's probably not as effective.

Christine Bechtel – National Partnership for Women & Families

Well, I mean, I agree with you that the menu has been a good signal, but I think that's not been its only purpose and there are fewer and fewer menu items proposed in Stage 2.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

Christine Bechtel – National Partnership for Women & Families

And so I think, but yet we have a real need to have flexibility for the program to suit a wide array of providers, you know, it maybe that it's exactly as you said, so that for primary care this would be really terrific but we cannot possibly ask everybody to do it and I think if we don't use menu for that purpose as well as for signaling purposes then the program actually ends up loses flexibility.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, I agree, but primary care that's hundreds of thousands of people so it's pretty wide.

Christine Bechtel – National Partnership for Women & Families

But, you understand the general…

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Christine Bechtel – National Partnership for Women & Families

But, what I'm saying is, yes it's widely applicable, but if there isn't a menu option on something and it does not make sense for a subset specialty to do it but they're going to get penalized we'll never hear the end of it. So there are some things that for certain specialist types, it's a program design issue and I just want to lose the flexibility, but I agree with the principle.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And there's one more that term feasibility, and another way of looking at it is it's within reach. As an extreme example -- even though a triquater would be really helpful in patient standards, it's just not within reach and we have to be on this glide path, because that's a policy issue, it's the whole country and all the specialists, we've got to be within reach.

Christine Bechtel – National Partnership for Women & Families

So, kind of the aspirational but achievable?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Achievable is probably a better way, you know, we have categorized things as aspirational, but achievable is a good way to say it.

Christine Bechtel – National Partnership for Women & Families

Right, no I was actually trying to combine both concepts which we have done in the past, which is to say that it needs to be aspirational but achievable like it can't be status quo.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, yeah.

Christine Bechtel – National Partnership for Women & Families

But, you know, an easy layup.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's right, well status quo would be topped out.

Christine Bechtel – National Partnership for Women & Families

Yeah, but it has to be achievable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Christine Bechtel – National Partnership for Women & Families

Okay, any feedback on Paul's suggestion?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I just, I don't know if we could add to the other feedback that we get a lot in our Workgroup is the need for specificity, so I don't know if achievable encompasses, it's probably different and I know we're at a balance between trying to keep things generalized enough so we don't prescribe, but on the other hand in the operational sense people want to know what to do, because this interpretation piece is a real barrier in terms of the program adoption and getting things done. So, I don't know how to encompass that concept. I think there's some really concrete things that are in here that are specific that we can get our arms around some of the others.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think your right, Charlene, would the word clarity help? So, that's not necessarily prescriptive, but clear, I mean ambiguity really has been a challenge to deal with.

Christine Bechtel – National Partnership for Women & Families

Okay, so clear in its meaning.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Christine Bechtel – National Partnership for Women & Families

And I think that one is going to be, you know, I think that one is going to be one that it will help us go through and identify, I mean we're at an early stage with this so we're not supposed to be uber specific or we're not, I don't think, Paul, about to go through and decide what's menu, core or where the thresholds are going to be, that's not where we are now, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, no.

Christine Bechtel – National Partnership for Women & Families

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But when we say whiteboard, well I mean we can't just leave it at that.

Christine Bechtel – National Partnership for Women & Families

Right, right, right, right, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, just have everybody…

Christine Bechtel – National Partnership for Women & Families

Yeah, well I agree but I think the idea of this principles list is to help us narrow down and focus in and so it may just be that because something isn't clear then it's either, we have to take it out if we don't know what it is, but I'm not sure, you know, well there might be 1 or 2 we don't know exactly or we have to just like write more narratives in this version.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Christine Bechtel – National Partnership for Women & Families

So, I think that's fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's a good list, Christine.

Christine Bechtel – National Partnership for Women & Families

Okay, all right, so I'll type the list up, I'll put it into the framework document so that we're just…I think I'll probably put it on the last page. So, I think what we've got is we're at the witching hour, so let's just have a 2 minute conversation here about process moving forward. What we need to do from my perspective is 2 potentially 3 things and I think that we can do some of this off-line and then before we get back on the phone and we'll try to kind of combine everybody's together. So, the first is to now go through these principles and apply them, and decide what can get combined, what comes out, what stays in. Then the second thing that we need to do is to work on, speaking of Charlene's last principle, the patient generated data pieces of this and I'm not sure the best way to do that we have someplace orders where we feel like, you know, there's something with potential but we don't know exactly how to operationalize it, it's not clear in meaning and there's a fair amount of redundancy. So those are the first two things that I think that we need to do.

Sequentially it would be helpful to have those who were really at the hearing…I don't know if we want to try to schedule a call just before that kind of patient reported data stuff and how it impacts this. I think the next call that we have, Michelle, if I'm not mistaken, is July 20th. Is that right? Is there one before then?

Michelle Nelson – Office of the National Coordinator

I thought there was one before then.

Christine Bechtel – National Partnership for Women & Families

It would be great if there was. Oh, maybe do we…

Michelle Nelson – Office of the National Coordinator

June 27th there is one.

Christine Bechtel – National Partnership for Women & Families

Oh, great. Okay, perfect. So perhaps what we can do then is since we have June 27th perhaps what we can do is people can work on the kind of application of the principles off-line and probably weaving aside some of the patient reported, patient generated data pieces until we get on the phone and we'll really focus in on those and on the parsimony and stuff on the 27th and then we'll go through and finalized after that before the last call on the 20th of July. Does that make sense to folks? I think I just changed what I said like three times. Do you want me to repeat it or did you all get it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, work on patient generated data in June?

Christine Bechtel – National Partnership for Women & Families

Yeah, I think work … right, so all of us would off-line go through and kind of apply these principles as an alternative I can take a shot at doing a first draft before I send this out, it won't be today, but I can get that done next week and send something out that is redlined and kind of cleaned up. Then everybody can go through and sort of apply the principles on their own to see where there could be some combining or eliminating or whatever. And then we would reserve the call on the 20th to really go back and take a closer look at the patient generated data pieces, but those of you who were at the hearing could do some redlining based on what you learned. Does that make sense?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, so giving us a cleaned up version of, you know, all the stuff that's been listed and then for us to sort of combine them, yeah, that would be great.

Christine Bechtel – National Partnership for Women & Families

Yeah, yeah, so what I'll do is I'll clean it up a bit and I'll start to take a crack at…I think there are some things that are sort of more almost commentary on Stage 2 that we can actually pull out of here, things like well the after visit summary isn't very useful and this is what we think should happen, but I'm not sure it's worth, you know, sort of the entire objective. So, why don't I take a crack at skinnying this down a little bit, send it out, you guys apply the principles on your own, send redlined versions back to Michelle. And those of you who were at the patient generated data hearing can also give thoughts on those aspects and then we'll get on the phone on the 27th of June to go over, one what will hopefully be a combined version of what everybody commented on. Is that all right? And if we can get you guys to give redlines by the 25th, Monday the 25th or even next Friday would be great, but Monday the 25th then Michelle and I can do some combining on Tuesday the 26th so that we can get something out in time for the call on the 27th.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Sounds good to me, this is Leslie.

Christine Bechtel – National Partnership for Women & Families

Great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you.

Christine Bechtel – National Partnership for Women & Families

All right, we do need to do public comment before we do it, any last questions, thoughts, issues that folks want to raise? Okay, great. Can we open the lines for public comment?

MacKenzie Robertson – Office of the National Coordinator

Operator can you please open the lines?

Public Comment

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comments at this time.

Christine Bechtel – National Partnership for Women & Families

Okay, I guess, I'm assuming we have no comments?

Caitlin Collins – Altarum Institute

We have no comment at this time.

Christine Bechtel – National Partnership for Women & Families
Okay, great, thanks everybody again and we will be in touch soon.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy
Thanks, bye.

MacKenzie Robertson – Office of the National Coordinator
Thanks everybody.

Christine Bechtel – National Partnership for Women & Families
Bye.